



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MIDLAND MEMORIAL HOSPITAL
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name

LIBERTY MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-12-2547-01

MFDR Date Received

April 6, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account. Per the new fee schedule this account qualifies for an Outlier payment . . ."

Amount in Dispute: \$2,606.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have included a copy of an APC pricer which does not include recommendation of any outliers. . . The charge for drug testing was paid under separate cover and a copy of that payment screen is also attached."

Response Submitted by: Liberty Mutual Insurance, PO Box 3423, Gainesville, Georgia 30503

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2011 to July 15, 2011	Outpatient Hospital Services	\$2,606.69	\$1,524.31

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
 - X687 – IF REIMBURSEMENT OF THE DRUG SCREENING, ALCOHOL SCREENING OR BOTH IS DEEMED APPROPRIATE AFTER ADDITIONAL REVIEW, PAYMENT WILL BE SENT UNDER SEPARATE COVER. (X687)
 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
 - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59. The recommended payment is \$18.59.
 - Procedure code 82055 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$15.21. 125% of this amount is \$19.01. The recommended payment is \$19.01.
 - Procedure code 82150 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.12. 125% of this amount is \$11.40. The recommended payment is \$11.40.

- Procedure code 83615 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$8.50. 125% of this amount is \$10.63. The recommended payment is \$10.63.
- Procedure code 83690 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$9.69. 125% of this amount is \$12.11. The recommended payment is \$12.11.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.68. The recommended payment is \$13.68.
- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$4.45. 125% of this amount is \$5.56. The recommended payment is \$5.56.
- Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This ancillary procedure code is packaged when submitted on the same date of service as the critical care E&M code 99291; however, as 99291 is not present, the criteria for composite payment are not met for this code. This service is paid separately and is not assigned to a composite APC. This procedure code is assigned status indicator X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$25.70. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.72. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$43.72. This amount multiplied by 200% yields a MAR of \$87.44.
- Procedure codes 71260 and 74177 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated CT imaging procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for CT imaging services including administration of a contrast agent. This composite APC has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. Per OPPS Addendum A, the payment rate for APC 8006 is \$628.61. This amount multiplied by 60% yields an unadjusted labor-related amount of \$377.17. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$358.69. The non-labor related portion is 40% of the APC rate or \$251.44. The sum of the labor and non-labor related amounts is \$610.13. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of \$2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.309. This ratio

multiplied by the summarized charges of \$8,300.00 yields a cost of \$2,564.70. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this composite service of \$610.13 divided by the sum of all APC payments is 63.09%. The sum of all packaged costs is \$87.49. The allocated portion of packaged costs is \$55.20. This amount added to the service cost yields a total cost for this composite line item of \$2,619.90. The cost of this service exceeds the annual fixed-dollar threshold of \$2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is \$1,552.17. 50% of this amount is \$776.09. The total APC payment for this service, including outlier payment, is \$1,386.22. This amount multiplied by 200% yields a MAR of \$2,772.43.

- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. This procedure code may be assigned to composite APC code 8003, for level II extended assessment and management services; however, the criteria for composite payment are not met for this code. This service is paid separately and is not assigned to a composite APC. This procedure code is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. This service is classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$127.01. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$216.04. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$216.04. This amount multiplied by 200% yields a MAR of \$432.08.
- Procedure code 96374 is unbundled. This procedure is a component service of procedure code 71260 performed on the same date. Per Medicare policy, these two codes may not be reported on the same date of service unless a modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Review of the submitted medical documentation finds that the modifier is supported; therefore, separate payment is allowed. This procedure code is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.13. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$21.05. The non-labor related portion is 40% of the APC rate or \$14.75. The sum of the labor and non-labor related amounts is \$35.80. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$35.80. This amount multiplied by 200% yields a MAR of \$71.60.
- Procedure code 96375 is unbundled. This procedure is a component service of procedure code 71260 performed on the same date. Per Medicare policy, these two codes may not be reported on the same date of service unless a modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Review of the submitted medical documentation finds that the modifier is supported; therefore, separate payment is allowed. This procedure code is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.13. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$21.05. The non-labor related portion is 40% of the APC rate or \$14.75. The sum of the labor and non-labor related amounts is \$35.80. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$35.80. This amount multiplied by 200% yields a MAR of \$71.60.
- Procedure code 90715 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9967 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of \$26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.81. This amount multiplied by the annual wage index for this facility of 0.951 yields an adjusted labor-related amount of \$15.04. The non-labor related portion is 40% of the APC rate or \$10.54. The sum of the labor and non-labor related amounts is \$25.58. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total APC payment for this service is \$25.58. This amount multiplied by 200% yields a MAR of \$51.16.
4. The total allowable reimbursement for the services in dispute is \$3,577.29. This amount less the amount previously paid by the insurance carrier of \$2,052.98 leaves an amount due to the requestor of \$1,524.31. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,524.31.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,524.31, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

November 19, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.